

## Ethical Aspects of Organ Allocation in Transplantation

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*Of the two major ethical issues surrounding organ allocation—determining criteria for expanding the size of the organ pool and determining criteria for allocation itself—I focus on the issue of allocation, and begin by assuming that there are five main criteria for use in deciding who gets a donor organ: age, medical benefit, merit, ability to pay, and geographical residence. I discuss each of these in turn, eliminating age because it fails to indicate the overall status of a patient's health; eliminating merit because physicians have neither the time nor the ability to act as judges; choosing medical benefit as the best criterion because it is fairest and does not call for such judgments; and leaving open considerations of ability to pay and geographical residence, for application in the event the issue cannot be decided on the ground of medical benefit alone. These criteria, I conclude, are best treated as guidelines, and not as rules. (Texas Heart Institute Journal 1987; 14:284-288)*

*Key words: Ethics, medical; transplantation, heart; organs, donor; organ allocation*

**N**OW THAT CARDIAC transplantation has become a well-established therapy for selected patients with end-stage cardiac disease, the ethical issues are different from those encountered during the late 60s. In the early years of cardiac transplantation, it was asked, "Can it be done? Should it be done? Is it ethical to do the procedure at all?" Now the question is more often "How do we decide who does it or who has it done to them?" Transplantation involves a complicated series of ethical problems, one of the most challenging of which is organ allocation. There are two major aspects of

this problem: one is to consider the various issues involved in determining the size of the organ pool, and the second is to define the criteria that determine how the organs gained from that pool shall be used. Because of space limitations, this article will focus on the second aspect.

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### CRITERIA FOR ALLOCATING DONOR ORGANS

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The five main criteria used for allocating donor organs are age, medical benefit, merit,

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*This paper is an adaptation of a talk given at a symposium titled "Diagnosis and Treatment of End-Stage Heart Disease: Heart Transplantation and Assist Devices, 1987," sponsored by the Texas Heart Institute and held February 5-7, 1987 at the Westin Galleria Hotel, Houston.*

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ability to pay, and geographical residence. Although other criteria exist, these five are so often discussed that they deserve to be considered in detail.

### **Age**

Because age is such a common focus in medicine, most medical records begin by stating the patient's age. How has our society traditionally viewed the question of age in relation to medical care? One often hears the argument that more is owed to persons who have not had many years of life than to those who have. In other words, the young person deserves the opportunity to eat in the three-star restaurant of life from which the older person has already tasted. Therefore, in the allocation of expensive, complicated technologies, it seems fair to think of younger persons as more deserving, because they have not yet had time to experience life in the same measure as older persons.

Another argument stresses not the subjective meaning of life to a particular individual but rather the meaning of that individual's life to society as a whole. Since older persons have fewer years to give back to society, the young are often thought to deserve more consideration. This used to be a standard point of view with respect to medical school admissions. Before the mid-1960s, many medical schools restricted eligibility to applicants under 30 years of age; part of the justification for that approach was the fact that applicants over 30 would have fewer years to devote to medicine after graduating.

There is a third way of considering this issue, based on the opposite point of view: some people argue that older persons deserve more consideration than young persons, because we owe a debt of gratitude to the elderly—to the mothers, fathers, grandparents, aunts, and uncles who nurtured us throughout our early years. How can we repay them? Surely one way is through the provision of needed medical care. If we deny the elderly this benefit, what gratitude have we expressed toward those who have made us what we are?

The basic problem with using age as a criterion for organ allocation is that age is generally assumed to indicate a patient's overall status or condition, especially with regard to physiologic capacity. A 50-year-old person, for example, is deemed less able to tolerate heart transplantation than a 40-year-old. (Indeed, age less than 50 has

commonly been a criterion for admission to heart transplantation programs.) Whereas this assumption is true in general, it is not necessarily true in specific cases. Some 40-year-olds are in worse physical shape than some 50-year-olds. Thus, age can be a stigmatizing factor that causes the medical profession to make misleading generalizations about patients and to ignore differences among them. If the real issue is physiologic ability to benefit, this criterion, rather than age, should be used. Because age can be such a misleading criterion, it should be broken down into the specific components that it stands for, which in turn should be individually weighed and evaluated.

### **Medical Benefit**

How should ability to benefit—as a concept—affect organ allocation? There are two ways of looking at the question of medical benefit: One is from the viewpoint of an objective observer such as an internist or surgeon, who must decide what benefit a particular organ transplant will have for a particular patient. The second viewpoint, which is critical, is the patient's—"What benefit will I get if I receive that organ?"

Unfortunately, these two points of view are sometimes at odds. Medical benefit can be a very good criterion for allocating resources, because it does not call for judgments about a patient's worthiness; use of this criterion can allow a decision to be based on a candidate's physiologic prognosis. The objective clinical observer asks first, "What is the status of this patient who appears before me? From a diagnostic and prognostic standpoint, what does this person need?" The observer must make a clinical, biological evaluation of the patient's condition. The second step is to ask, "What can I do for this patient?" That involves three rather technical considerations:

The first is whether the technology, *per se*, is good enough to produce a benefit. This question is often asked today, for instance, with respect to the artificial heart.

The second consideration has to do not with the technology but with the people who implement it and the institution in which they work: "In this hospital, with this doctor, will the patient likely receive a benefit?" During the last few years, a number of studies have demonstrated that, for the very same procedure, the results vary with different hospitals, different physi-

cians, and even different teams. This is probably why, when Medicare recently agreed to pay for heart transplantation, they stipulated that they would do so only at a small number of selected centers with a proven record of good results.

The third consideration is, of course, the patient. Is he or she able to benefit from the technology and the physician's skill, as the staff sees it?

That is the medical profession's view of medical benefit. What about the patient's viewpoint? Some patients, when told what they can expect after a procedure, will say, "No, I don't want to live that way," even though the physician might think the quality of life is all right. This poses an interesting problem. In evaluating medical benefit, physicians often think of it in the long term. They speculate about how the patient's life will be several years after surgery: Will that person be able to function at work? Will he or she be able to satisfactorily experience a variety of life events? When physicians start asking themselves these questions, they are beginning to leave the realm of biological, clinical, and technological benefits. They become involved in evaluating the quality of their patients' lives. As soon as one tries to predict how a person will live at some future date after the treatment has been administered, we begin to tread on very slippery ground. Therefore, in using the criterion of medical benefit to deal with these issues, we must take great care to integrate into our perspective the views of the patients themselves about how their physical limitations will change their lives and what these changes will mean in terms of productivity and inner satisfaction.

### **Merit**

The third way of considering the problem of allocation has to do with merit. This criterion was one of those applied in the initial allocation of high-technology resources when, in 1960, the first renal dialysis center was opened in Seattle. Is this a valid way for us, as medical professionals, to think about our patients? Should we examine their past? Is a patient who has contributed much to the community more deserving than one who has been detrimental? Should priests, as a group, receive more consideration than alcoholics? This brings up another question: Should the way a patient got sick influence the way that patient is treated? This question has a

clear implication for liver transplantation. How should the medical profession regard patients with alcoholic cirrhosis? Should these patients be denied help because they, themselves, seem to have caused their predicament? Of course, this question is becoming more and more moot, since there is growing evidence that alcoholism is influenced by genetic factors that patients can't control. Nonetheless, assuming that an alcoholic can control drinking—at least at the beginning—should the fact that these persons helped initiate their own illness affect what treatment is given them? All of these considerations come under the heading of "merit."

As physicians, most of us are not prepared to judge who is deserving or who is at fault. Further, we would not have the time to inquire into a person's life, even if we did have the skill. Moreover, the last thing the medical profession or the hospital should do is to judge people. After all, what do we ask of our patients? We ask that they be honest and candid with us about their lives, so that we can learn as much as possible about what caused their illness—and about their needs, so that we can be therapeutic. How could we ever expect trust or candor from our patients if they believed that their honesty would be used against them—if they believed that we were judging them or taking account of the lives they have led in deciding what we would do for them? Doctor-patient relationships would become impossible. One of the most powerful benefits medicine confers on society is to provide an oasis where all may come to unburden themselves and be cared for to the fullest possible extent. There are few other such oases in our society; thus, it is important that medicine remain one. If physicians allocated resources according to the kind of life their patients have led, they could no longer remain physicians: They would assume the role of courtroom judges, in whom patients could not confide without fear of reprisal. Therefore, in the allocation of medical resources, I think that merit should be disregarded.

### **Ability to Pay**

Ability to pay is a particularly troublesome issue. Early in the history of our republic, we began to realize that, in the case of certain people with special, expensive, long-term medical needs, social intervention was necessary. It was not fair to burden them with the problem of

payment. This approach was manifested early, with the development in the 19th century of hospitals for the tubercular, the infectious, and the mentally ill. Historically, Americans have insisted that those who could pay *should* pay, but we have designated special groups of needy patients with long-term, expensive illnesses, to whom we grant the right to medical care without payment.

When the Medicare Act was passed in 1965, it represented a break with the past, in that the federal government had never before been involved to such a massive extent in health-services delivery. Nonetheless, Medicare was undertaken in the same spirit as the 19th-century legislation that ensured free care for people with tuberculosis and mental illness—that is to say, the elderly were designated as an especially needy group. When Medicaid legislation to deal with the poor was passed in the following year, it was based on the same approach, which was previously embodied in the building of public hospitals for the poor.

That is one way to deal with the issue of ability to pay. A second way has been for doctors, on their own, to treat certain patients free of charge. In the past, to make up for this free care, some have charged wealthier patients higher-than-average fees. This behavior invokes the legend of Robin Hood, the English adventurer who, with his collaborators, would await well-to-do people riding through the wood and would relieve them of their purses in order to help the needy. The Robin Hood concept of medicine presents a problem. The wealthy person, if not informed about what Robin Hood is doing, is being acted upon in a way he or she might not approve if the truth were known. In other words, suppose the physician explains to a wealthy patient, undergoing a certain procedure, that he or she is being charged extra in order to benefit others who need the same procedure but can't afford it. Some patients might agree with this reasoning and find the situation totally acceptable; some might not. Moreover, if the Robin Hood concept is to make sense, the wealthy "donor" would have to be assured that the money would indeed be used to help the poor.

Actually, the Robin Hood principle has become more and more difficult to apply because, before high technology became available in the 1960s, the doctor's services often

constituted the essence of the therapy; the physician's time was the most critical variable that could be given to a patient. In these days of high-technology medicine, however, the physician needs the hospital's facilities and staff. Therefore, it is much more difficult to give free services.

The third way of dealing with this issue is to treat people in relatively equal ways—in other words, to provide similar treatment for similar cases. Ideally, to a patient who needed a kidney or heart transplant, the physician would say, "If I was able to justify giving this treatment to Patient A, who had a given illness and a given set of problems, and to other patients like A, then I would also—and should, in fact—give it to you, too." That, of course, would be the ideal.

The problem is that ability to pay is an issue that essentially should be solved on a national level. Nevertheless, the national government has said that it will not provide enough resources to allow similar cases to receive similar treatment. The next levels of government—the state and local levels—are basically involved in education and clearly do not at present have the resources to fully support medical care. Therefore, it comes down to the hospitals. It seems unfair to take the ideal goal, similar treatment for similar cases, and tell the hospitals, "Look, the patient has come to your door; you have to figure out a way to achieve this goal." No hospital has the resources to be able to meet this challenge. Accordingly, because of the way our country has decided to give medical care, ability to pay must enter into decisions about treatment.

The concept of the hospital as a philanthropic institution, as well as the requirements of the Hill-Burton legislation regarding hospital construction, tend to ensure that a certain percentage of a hospital's gross income will be devoted to the care of indigent patients. Nevertheless, to devote it all to ten or twenty transplant patients, for example, would eat it up quickly and make it impossible to treat others who are equally needy. Thus, our system is a mixed one that makes for much perplexity, because at some levels, government officials are saying, "Let's make the idea of similar treatment for similar cases work," while at other levels, they are telling patients, "We can't help you, because you don't qualify for Medicare or Medicaid."

## Geographical Residence

The fifth criterion is allocation according to geographical residence. In Seattle, when the first artificial kidney dialysis center was opened, a geographical criterion was used to help allocate this resource. The patients in the five-state area around Seattle were eligible for the program, but others were not. What about that? Should a community reserve its resources for those who reside in it? No doubt, everyone has heard the old story about the little red hen: how she found some grain on the ground and decided to make bread. She went to all of her barnyard friends and asked them to help with the various aspects of the project, but each one had something more important to do. So she decided to do it herself. Finally, when the bread was removed from the oven and turned out to be a fine loaf, all the barnyard animals came around and asked for a piece. The little hen pointed out that, since they hadn't helped in the separate aspects of the project—the threshing, grinding, and baking—she would eat it herself.

This story is applicable to the issue of organ allocation. If communities have created public education campaigns to encourage donation and have developed their resources and skills so as to be able to use the donor organs, these communities certainly have a right to those organs. But should their right be absolute? “Texas organs for Texans.” Would that be a logical motto? New Englanders or Californians would certainly not think so. Clearly, each local community is part of a larger national community, and to engage in the “little red hen” argument too voraciously would only foster divisiveness. With respect to candidates from abroad, who are not American citizens, the dilemma is even more perplexing.

One approach to the whole problem would be to have a system that depended on medical benefit: if the medical benefit were greater for a distant applicant than for a local resident and if

the difference in benefit were significant, it would make sense to send the organ to the distant patient. Given similar medical benefit for a distant applicant and a local one, it would seem logical to use the organ locally. This is actually the way it is done now, and it seems to be appropriate. Similarly, when a foreign transplant candidate travels to the United States, he or she should be allowed to wait in line. The greatest difficulty arises when a foreigner or other distant applicant is allowed to buy a more advantageous place in line. If money can be used to determine an applicant's place in line—if fairness does not enter into the allocation of these scarce, precious commodities—the system is in deep trouble.

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## CONCLUDING COMMENTS

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I believe that the best criterion—at least, the one with which I am most comfortable—is medical benefit. If the issue cannot be decided on the basis of medical benefit alone, one could bring in other criteria such as ability to pay and geographical considerations. Merit should be avoided. Age, *per se*, as a specific criterion, should also be avoided; rather, it should be broken down into the issues for which it stands, the most significant of which is ability to benefit. This produces a dilemma, however: as a person grows older, medical benefit usually diminishes, since older patients have decreased organ reserve and capacity. This decreased ability to benefit should be balanced against the value of gratitude. This will ensure that the elderly are not denied a “fair” share of our resources.

In conclusion, the criteria outlined above are not meant to be treated rigidly. They are concepts that may help medical professionals weigh the various issues and make the complicated and difficult decisions that must be faced in dealing with transplant patients and their families.